COLLABORATION BETWEEN TITLES I AND II AND CDC HIV PREVENTION COMMUNITY PLANNING GROUPS

TECHNICAL ASSISTANCE CONFERENCE CALL

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Arranged by:

Division of HIV Services
Bureau of Health Resources Development
Health Resources and Services Administration
U.S. Department of Health and Human Services

Report prepared by:

MOSAICA
The Center for Nonprofit Development and Pluralism
1000 16th Street, N.W.
Suite 604
Washington, DC 20036

EXECUTIVE SUMMARY

This report summarizes information presented in "Collaboration between Titles I and II and CDC HIV Prevention Community Planning Groups," the seventh in a series of nationally broadcast technical assistance audioconferences arranged by the Division of HIV Services (DHS), Health Resources and Services Administration (HRSA). This summary reflects both the content of the presentations and the questions and comments from listeners during the call, which was broadcast on September 18, 1995, reaching more than 850 people at 174 sites nationwide.

The purpose of the conference call was to improve the continuum of care for people living with HIV disease and those who are at risk, by facilitating increased cooperation and collaboration between HIV Prevention Community Planning Groups and both Ryan White CARE Act Title I Planning Councils and Title II Care Consortia.

The audioconference demonstrated that both HRSA and CDC believe that coordination and collaboration between prevention and care planning bodies are vital to creating and maintaining a continuum of high quality care for people at risk for HIV and those living with HIV disease. HRSA believes that to plan effectively for continuity of care, HIV care planning bodies, planning councils, states, and consortia need to coordinate with prevention planning groups. CDC has an explicitly stated expectation that there will be both collaboration and information sharing between prevention and care planning activities. Both entities also recognize that such collaboration can take many forms. The Guidances issued by both agencies ask for information about collaboration between prevention and care planning bodies, but recognize the need for flexibility in how that collaboration occurs in any specific state or area.

Collaboration between prevention and care planning bodies is in its early stages. CDC HIV Prevention Community Planning began in 1994, and the compressed time frame available to community planning groups for developing a prevention planning structure, recruiting membership, and completing the tasks necessary to develop a comprehensive HIV prevention plan limited the time available for developing collaboration. Both HRSA and CDC expect that cooperation and collaboration will increase in future years.

Case studies from selected Title I and Title II jurisdictions identify a wide range of types of collaboration, from a consolidated planning group to memoranda of agreement which call for some joint activities, some shared membership, and/or information sharing. Certain types of activities, such as the development of an epidemiologic profile, other components of needs assessments, and development of resource inventories seem particularly appropriate for joint efforts. Other activities, such as priority setting, may be more effective if handled separately.

Although HIV Prevention Community Planning is similar to CARE Act planning in terms of certain planning group responsibilities and processes, the two differ in terms of the priority setting and resource allocation processes. Both HIV Prevention Community Planning Groups and CARE Act planning bodies have comprehensive planning responsibilities. In HIV Prevention Community Planning, the Health Department has sole responsibility for resource allocation. Under the CARE Act, however, the Title I Planning Council has the additional responsibility for establishing the allocation of resources across service priorities (usually done as an absolute dollar amount or as a percentage). CARE Act Title I Grantees have the administrative responsibility of soliciting and awarding contracts that result in service provision consistent with established priorities (the procurement process). The relationship between a Title II Consortium and the CARE Act Title II Grantee is somewhat similar to the relationship between the HIV Prevention Community Planning Group and the Health Department concerning the allocation of funds, although this is not necessarily always the case given the variety of consortia models.

Certain factors create an environment conducive to collaborative planning. Collaboration has been shown to work well in jurisdictions which are relatively rural with a limited number of community agencies conducting HIV/AIDS-related activities, and in jurisdictions which have Health Departments and public health systems that are well integrated at both the state and local levels.

The experience gained to date suggests both the value of collaboration and some strategies which contribute to successful joint efforts. Effective collaboration can make effective use of human and financial resources, improve the extent and quality of planning, and help to create and maintain a continuum of care including both prevention and treatment.

TABLE OF CONTENTS

I. INTRODUCTION

A. PURPOSE

This report summarizes the information presented in "Collaboration between Titles I and II and CDC HIV Prevention Community Planning Groups," the seventh in a series of nationally broadcast technical assistance audioconferences arranged by the Division of HIV Services (DHS), Health Resources and Services Administration (HRSA). This summary presents both the content of the presentations and the questions and comments from listeners during the call, which was broadcast on September 18, 1995.

Each of the conference calls is designed to provide a forum for exchanging information and models regarding specific implementation and policy issues related to the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. This conference call was designed to improve the continuum of care for people living with HIV disease and those who are at risk, by encouraging increased cooperation and collaboration between HIV Prevention Community Planning Groups and both Ryan White CARE Act Title I Planning Councils and Title II Care Consortia. Emphasis was placed on sharing experiences with collaboration, identifying the benefits of collaboration, and identifying obstacles and how they can be minimized or overcome.

The conference call included panelists from the DHS and the Centers for Disease Control and Prevention (CDC), and from planning councils, consortia, and HIV prevention community planning groups. (See Appendix A for a list of panelists, with contact information, and Appendix B for the agenda.)

B. PROCESS

The audioconference addressed topics and questions submitted by a variety of sources, including Title I and Title II grantees, consortium and planning council members, CDC HIV Prevention Community Planning Group chairs and other community planning group members, and CARE Act-funded providers. In addition, listeners had an opportunity to ask questions during the call. Over 850 people at 174 sites throughout the country participated in the conference call.

II. THE FEDERAL ROLE IN COLLABORATION

A. LEGISLATIVE REQUIREMENTS FOR COLLABORATION

At the time of the conference call, final action on the House bill to reauthorize the Ryan White CARE Act was imminent. As of the end of September 1995, reauthorization bills

had been passed by both the House and the Senate and were awaiting action by a conference committee.

Neither bill specifically mentions collaboration with HIV prevention community planning groups, but the bills do contain a provision to ensure that HRSA coordinates with CDC and other federal HIV programs. The bills also require submission of an annual report on this collaborative activity. However, the House bill report language specifically mentions grantees under other HIV-related federal programs including prevention programs for representation among planning council membership, which sets up an expectation that prevention planning programs will be represented on Title I Planning Councils.

B. HRSA ROLE

1. HRSA'S EXPECTATIONS FOR COLLABORATION

HRSA believes that to plan effectively for continuity of care, HIV care planning bodies, planning councils, states, and consortia need to coordinate with prevention planning groups. HRSA's expectation is that coordinated planning will occur between prevention and care. However, HRSA recognizes the need for flexibility in how that collaboration occurs in any specific state or area.

HRSA's priorities for coordination between prevention and care planning groups are shown in the box. Especially important is ACTG 076. Both Title I and Title II Guidances focus on how programs related to ACTG 076 are participating in the broader local planning process, including prevention planning for counseling and testing and referral to care settings, as well as HIV services planning to meet the treatment needs of HIV-infected pregnant women who elect the ACTG 076 protocol for themselves and their children.

PRIORITIES FOR PREVENTION AND CARE PLANNING COORDINATION

- ACTG 076, to reduce perinatal transmission of HIV
- Outreach
- Education and risk reduction activities
- Consideration of the effectiveness of ongoing prevention activities in the context of care programs

HRSA identifies a number of examples of the ways in which coordination may occur in many ways, such as the following:

- Representation of prevention planning group members on planning councils and consortia;

- Participation of planning group members as ad hoc members on committees or subcommittees of councils and consortia;

- Joint needs assessments

- Joint planning processes

- Memoranda of agreement or other written agreements specifying how referral processes will take place, calling for regular meetings of staff from prevention and care planning bodies, and/or identifying joint processes feeding into the same larger planning entity.

2. CARE ACT APPLICATION GUIDANCES

The CARE Act FY 1996 Application Guidance for States and the CARE Act FY 1996 Supplemental Grant Application Guidance for EMAs include requests for information about collaboration between prevention and care planning bodies.

The Title I supplemental application Guidance includes a section on coordination and collaboration (see page 25 of the Guidance); similar sections have been included in previous Guidances. The section does the following:

- Asks applicants to describe their past coordination activities with a number of critical programs, including HIV-AIDS prevention, counseling, and testing programs, including the CDC's HIV Prevention Community Planning Groups.

- Requests a description of the type(s) of coordination in use by the applicant in order to promote an accessible continuum of care for HIV-infected persons.

- Asks applicants to provide a short narrative of those coordination activities which have been particularly successful or have been initiated to address especially difficult programs.

The Title II Guidance for Fiscal Year 1996 includes a new section on coordination planning which requests information about the following (see page 5 of the Guidance):

- How states are progressing in the planning process; and

- How they work and plan with other titles of the CARE Act, the CDC HIV Prevention Community Planning process, and other HIV care groups.

The Guidance also asks states to provide a two-page narrative describing coordination planning efforts which are under way, or plans to move towards more coordinated planning among CARE and prevention programs.

C. CDC ROLE

1. CDC EXPECTATIONS FOR COLLABORATION

CDC has an explicitly stated expectation that there will be both collaboration and information sharing between prevention and care planning activities. As one portion of the comprehensive HIV prevention plan that is to be prepared, CDC specifically asks for a description of how primary and secondary HIV prevention activities are being coordinated within the jurisdiction. Groups are expected to be aware of each other's activities and of opportunities for collaboration. CDC recognizes that collaboration can take a number of forms, from a fully merged joint process to shared membership, with individuals who serve on CARE Act planning groups also serving on HIV Prevention Community Planning Groups, or various levels of cooperative activities and/or information sharing.

2. HIV PREVENTION COMMUNITY PLANNING GROUPS APPLICATION GUIDANCE

The CDC Guidance for HIV Prevention Community Planning issued in December 1993 specifically mentions the CARE Act and advises all the planning groups to be routinely informed about the activities of CARE Act planning bodies. The Guidance mentions that grantees should consider merging the prevention planning process with other planning processes already in place, such as CARE Act planning bodies, but this is not required or mandated.

RESPONSIBILITIES OF HIV PREVENTION COMMUNITY PLANNING GROUPS

The CDC Guidance identifies the following major responsibilities for community planning groups:

- Assessing the epidemic;
- Identifying unmet HIV prevention needs; and
- Identifying specific high-priority interventions and strategies to address those needs.

D. TECHNICAL ASSISTANCE AVAILABLE TO GRANTEES

Both HRSA and CDC can make available technical assistance to help grantees with collaboration.

CARE Act grantees can request technical assistance through their HRSA project officers at the Division of HIV Services. Peer and external consultants can be made available to respond to individual requests. Some of the state and local collaborative strategies identified for this audioconference call may be used as models, and it may be possible to use individuals involved with these collaborative efforts as peer consultants. In addition to this report, HRSA expects to provide opportunities for further discussion of this issue at future Title I and II CARE Act national meetings.

HIV Prevention Community Planning Groups can also request technical assistance on collaboration through their CDC project officers. Each of the more than 200 community planning groups can work with its Health Department to request input from CDC concerning appropriate technical assistance. CDC can then call upon its network of national and regional technical assistance providers to meet specific needs. In addition, Health Departments are permitted to use a portion of their cooperative agreement funds for training and technical assistance activities.

JURISDICTIONS REPORTING COOPERATION AND COLLABORATION BETWEEN PREVENTION AND CARE PLANNING

Jurisdictions with coordinated planning processes:

- Alabama
- Delaware
- Florida
- Michigan
- Washington State
- City and County of Los Angeles

Jurisdictions with more limited collaboration:

- California
- Chicago
- Maryland
- New Mexico
- New York
- Utah

II. CASE STUDIES: WORKING TOGETHER

A. EXTENT OF COLLABORATION

CDC estimates that during the first year of HIV Prevention Community Planning, a fairly small number of grantees -- less than 10% -- opted to merge the prevention and care planning processes. The process is now in its second year, and numerous planning bodies have devised methods of working together without necessarily merging.

In 1995, the National Association of State and Territorial AIDS Directors (NASTAD) conducted a survey of all the Health Departments involved in HIV

Prevention Community Planning. The survey found that six jurisdictions -- five states and one city -- reported that their prevention planning process is coordinated with CARE Act services planning. This means six project areas out of a total of 65 CARE Act grantees nationwide, and about 10 out of 175 community planning groups nationwide. Some additional areas report more limited collaboration (see box).

Case studies from three of the jurisdictions with coordinated planning (Seattle-King County, Washington; Michigan; and Alabama) and one with more limited collaboration (New York City) are presented below.

B. TITLE I GRANTEE EXPERIENCES: WORKING TOGETHER

1. SEATTLE-KING COUNTY, WASHINGTON

The 32-member Ryan White Care Act Title I Planning Council in Seattle-King County, Washington encompasses both prevention and care planning. The council actually began in 1988 when the State of Washington allocated funds for HIV prevention and created a regional AIDS network of six regions which together provided a network for statewide planning. In 1992, the Title I planning council was formed, and an affirmative decision was made to have one council responsible for both prevention and care planning. The original State AIDS network committee became a part of the CARE Act system, responsible for the allocation of state prevention funds as well as planning for the utilization of Ryan White funding.

In 1994, when the CDC Guidance for HIV Prevention Community Planning was issued, Seattle-King County already had a process for allocation of state prevention funds, so the planning council became the body responsible for CDC prevention planning as well.

By the end of 1994, it had become clear that the planning council and the Health Department were unclear about their roles. In the spring of 1995, the "Gang of Seven" -- three representatives from the planning council, three from the Health Department, and the Planning Council Coordinator -- came together to clarify the roles and responsibilities of the Council and the Department. Over several months, the group developed several products which were brought back to the Director of the Health Department and the full membership of the Council, and in August the membership approved the following for use during a one-year period:

- A memorandum of agreement;
- A definition of the roles and responsibilities of the two groups, clarifying responsibilities for such tasks as needs assessment, priority setting, funds allocation, evaluation, policy development, technical assistance, governance, advocacy, and community relations;
- A staffing model; and

- A conflict resolution model.

The following factors are seen as complicating the combined prevention and CARE planning processes in Seattle-King County:

- **Inconsistent planning area boundaries:** The boundaries of the Title I EMA (eligible metropolitan area) are different from the prevention planning area and the Title II area; one Washington county is in another state's EMA, and two other counties are considered part of King County's EMA.

- **The Title I administrative cap:** The 5% funding cap hinders the complete staffing and work of the planning council. (Although DHS allows for additional funds to be used for Planning Council support, if the activities are designated as priorities by the Council.)

- **Inconsistent grant years:** The formula and supplemental grant years for HRSA and the grant year for the CDC Prevention are different.

- **A planning "bureaucracy":** There is a complicated and overlapping mix of state and local planning groups for HRSA and CDC programs.

2. NEW YORK CITY

New York City is directly funded for both prevention and Title I. Because these programs are direct and substantial in size, the planning needs are sophisticated and wide-ranging. The community has been involved in prevention planning since 1986. The Health Department has had extensive contracts with community-based organizations and therefore has had community members advising its programs for years. The HIV Prevention Community Planning Process led to the institutionalization of this advisory capacity.

When the City established its prevention planning group, it wanted to ensure that the new body would have some independence from the CARE Act Title I Planning Council so that it could develop its own voice and establish its own identity and function. The two bodies also have different types of authority. The planning council is appointed by the Mayor and has the authority to set priorities for the allocation of funds for various service categories, while the community planning group is appointed by the Commissioner of Health and serves in an advisory capacity, identifying needs and priorities. However, coordination occurs at several levels:

- **Staffing:** A good deal of coordination occurs across staffs. The Assistant Commissioner for HIV Prevention Programs and the Assistant Commissioner for Ryan White Services coordinate programs such as case management for early intervention. They both report to the Deputy Commissioner and Commissioner of Health, who encourage coordination.

- **Membership:** The Chairperson of the planning council -- who is the Coordinator of Citywide AIDS Policy -- has a seat on the prevention planning group; this is specified in the planning group's bylaws. There is other intentional overlap in membership, including governmental representatives, community members, and representatives of people living with HIV/AIDS.

- **Participation in meetings:** The Director of the Prevention Planning and Evaluation Unit within the Department of Health regularly attends planning council meetings. Similarly, Title I and Title II staff other than the Coordinator of Citywide AIDS Policy regularly attend prevention planning meetings.

Now that the community planning group has been in existence for over a year, and has established its identity and function, discussions have begun concerning the possibility of more formal coordination such as some kind of intergroup task force. Coordination planned for the future also includes the following:

- **Sharing epidemiological data and information;** and

- **Sharing needs assessment information about services,** especially what services are and are not available, and how services are able to coordinate prevention and care across a continuum of care.

C. TITLE II GRANTEE EXPERIENCES: WORKING TOGETHER

1. MICHIGAN

Michigan is considered a medium-incidence state. It has a cumulative total of just over 7,000 reported AIDS cases, and an estimated 8,500 to 11,500 additional persons living with HIV disease.

The Michigan Department of Health has responsibility for both Ryan White Title II and the CDC cooperative agreement for prevention. A little over two years ago, the state was divided into eight geographic regions in order to provide care resources statewide. When the CDC Guidance was issued for prevention planning, the State retained those same defined geographic areas for prevention planning. The result was eight regional care consortia and eight regional planning groups, plus one statewide planning group for prevention and one statewide Title II consortium.

In the spring of 1995, the Governor's major advisory group on AIDS policies and budgets, the Risk Reduction and AIDS Policy Commission, directed the Health Department to begin to consolidate the efforts of these regional planning groups and care consortia over a two-year period. They did not specify rigid requirements for consolidation, but did lay out some minimum expectations:

- The care consortia and planning groups must coordinate and collaborate effectively, but the groups need not become a single entity at either the regional or state level.

- It is very important to preserve both the agendas of care and prevention, while providing high quality services.

The consolidation is expected to increase effectiveness and efficiency. The process is moving slowly in order to ensure appropriate decisions. The box identifies expected types of potential cooperation and collaboration.

EXPECTED TYPES OF COOPERATION TO RESULT FROM CONSOLIDATION OF MICHIGAN'S PREVENTION AND CARE PLANNING GROUPS

- Since both the consortia and prevention planning groups must identify gaps and assess needs, they can use common epidemiological profiles, common focus groups, and common public hearings, and work together to develop resource inventories and directories.

- The groups may collaborate in the identification of priorities, especially priority setting for secondary disease prevention and the prevention of perinatal transmission.

- Prevention and care planning groups can hold common meetings in the same facility at the same time, or at least on consecutive days.

- Consistent technical assistance can be provided to the groups -- through both state and federal sources -- if they have problems in conflict resolution, priority setting, interpreting epidemiological profiles, or other specific areas.

2. ALABAMA

Alabama has established a coordinated prevention and care planning process. The state has Title II funding but no Title I EMA. Alabama is divided into eight public health areas, and each area has an HIV Coordinator responsible for both prevention and care efforts. Each area has both a regional Title II consortium and HIV Prevention Community Planning Group.

To qualify for prevention or care funding, an agency is required to participate in a planning group. Since most agencies provide both prevention and care services, most are on both planning groups. CARE Act funding also supports five Title III early intervention clinics, one Title IV pediatric project, and one SPNS (Special Projects of National Significance) project. All these providers have representatives on each of the area care and prevention planning groups. Three of the clinics are located in a local health department, and operate as collaboratives between the health department and a community-based organization.

There is a statewide Title II consortium, called the CARE HIV Advisory Council. No formal statewide prevention group exists, but the co-chairs of the eight regional prevention planning groups meet as a group with the State Health Department to plan, coordinate, and review the comprehensive prevention plan before it is submitted to CDC.

The prevention and care planning groups share information and collaborate on their needs assessment activities. The state has developed a suggested integrated needs assessment process, which is carried out through one survey. The State Surveillance Branch prepares a regionalized epidemiological profile which is shared with both statewide groups, and a state-level epidemiologist provides technical assistance to both groups in the development and analysis of the state profile. Through the area HIV Coordinators, prevention and care planning groups share their needs assessment, resource inventories, and plans.

FACTORS CONDUCIVE TO COLLABORATIVE PLANNING IN ALABAMA

- Largely rural character of the state
- Limited number of community agencies conducting HIV activities
- Organization of the state program to include all components under one division
- State-coordinated public health area system with an area HIV coordinator who ensures information sharing between prevention and planning groups
- State coordination of information sharing among AIDS service organizations

Each October, the Health Department holds a statewide AIDS symposium. On the last day of the symposium, time is scheduled for meetings of the individual public health areas. The area HIV Coordinator facilitates the meeting, and both CARE Act consortium and CDC prevention planning groups have an opportunity to present their activities, share their successes and failures, and seek ideas from others for resolution of identified problems.

Alabama has identified five factors conducive to collaborative planning, which are shown in the box. These factors relate to both the rural character of the state and the relatively small number of HIV/AIDS service providers and to the organization of HIV/AIDS programs within the Health Department.

D. COLLABORATION ISSUES

1. TYPES OF COLLABORATION

As the case studies demonstrate, collaboration does not always mean creating one merged planning group. Most collaboration between prevention and care planning involves other permutations of structure. The two most prevalent current types of collaboration in terms of structural arrangements are reportedly the following:

- Two planning groups with a joint operating agreement and some joint membership; and

- Cooperation between certain subgroups of local planning bodies which exist and operate independently.

Substantively, collaboration can include different levels and types of cooperative effort, from information sharing to joint preparation of needs assessments and resource inventories and joint priority setting. A few jurisdictions have merged their prevention and care planning groups; more often separate groups have agreed on certain joint activities, identification of several common members, and/or regular attendance at both meetings by certain individuals who are not members.

2. AGENCY VERSUS COMMUNITY REPRESENTATION ON PLANNING GROUPS

One of the issues of concern when a jurisdiction decides to consolidate its prevention and care planning groups is how to balance community input and agency representation on the planning group. There is a fear that consolidation may lead to an over-representation of agency perspectives.

In Michigan, the Title II care consortium will begin using the CDC requirements for parity, inclusion, and representation and for community involvement, especially the involvement of people living with HIV disease. Attention is being paid to maintaining an adequate balance between prevention and care providers and community representatives. Creating a body which is representative of the epidemic in a particular community is difficult, but important.

In Alabama, the groups have open membership -- anyone can join. Outreach is done to seek broad representation, and each group decides on a voting process which provides input from both the community and agencies.

3. MAXIMIZING PARTICIPATION IN PLANNING

Another concern in collaboration is how to maintain and enhance participation by as many people as possible, including individuals who have been active on one or both planning bodies. A combined planning process can effectively involve people from both bodies. For example, there might be a joint town hall meeting or use of the same focus group -- with some questions directed towards primary prevention and some towards treatment and care. Also important is reinforcing the message that input is not just sitting on one of these planning groups; there are other ways for individuals to participate in the process. Some populations that are particularly important -- such as injecting drug users -- may be unlikely to join a committee. A variety of processes need to be used in obtaining input and at the same time streamlining processes so that the efforts meet multiple goals.

4. REGIONAL VERSUS STATEWIDE PLANNING GROUPS

Some states have regional planning groups and others have one statewide group. The question was raised as to whether it is a "progression or regression" to consolidate ten regional prevention planning groups into a single statewide group which obtains recommendations from each region.

CDC has a statewide cooperative agreement with fifty states. This means that at some point the recommendations and priorities from a number of different regions must be combined to provide a central focus, and the Health Department must make decisions about how funds will be allocated. Resources are not sufficient to meet all needs.

A critical concern which was raised is what is the best vehicle to communicate information from the local to the state level. Each region is likely to have both similar and different factors that need to be reviewed in the development of a prevention plan. If the people at the local level are able to truly get their voice heard at the statewide level in terms of influencing funding allocations, then a consolidated process may be very positive. If the people at the local level feel shut out, and believe that their planning and prioritization process is not given much weight compared to the mechanics of funds allocation, then problems may follow. It is important to look very carefully at what is happening to priorities as recommendations move from the regional to the state level, while understanding that not all priorities will be met. If region X had three top priorities, at least some of those priorities should be identifiable within the centralized state plan.

5. ALLOCATION OF RESOURCES FOR PREVENTION

Although HIV Prevention Community Planning is similar to CARE Act planning in terms of certain planning group responsibilities and processes, the two differ in terms of the priority setting and resource allocation processes. Both HIV Prevention Community Planning Groups and CARE Act planning bodies have comprehensive planning responsibilities. In HIV Prevention Community Planning, the Health Department has sole responsibility for resource allocation. Under the CARE Act, however, the Title I Planning Council has the additional responsibility for establishing the allocation of resources across service priorities (usually done as an absolute dollar amount or as a percentage). CARE Act Title I Grantees have the administrative responsibility of soliciting and awarding contracts that result in service provision consistent with established priorities (the procurement process). The relationship between a Title II Consortium and the CARE Act Title II Grantee is somewhat similar to the relationship between the HIV Prevention Community Planning Group and the Health Department concerning the allocation of funds, although this is not necessarily always the case given the variety of consortia models.

A number of approaches have been used in determining how funds for prevention are to be allocated.

In Seattle-King County, groups representing the prevention and care planning council has carried out a prioritization of target groups and target interventions based on the needs assessment conducted for the area, and the Health Department will carry out an allocation process based on the recommendations from these groups. The Health Department's Request for Proposals (RFP) for care and prevention funding will adhere to the percentages included in these prioritizations.

In New York City, the prevention planning group recently adopted a new matrix for the relative distribution of prevention resources based on risk behavior, and in particular the ability to identify types of behavior that put certain populations at risk. The matrix looks at three levels of prevention activities and is applied to a fairly complex set of target populations. This matrix will be applied in allocating resources for the CDC cooperative agreement.

In general, CDC has found that the "translation" steps of the community planning process -- the steps through which identified needs and program gaps are translated into funding priorities -- represent profound challenges. One of the most important translation steps is priority setting. When CDC reviews applications at a national level, it looks to see whether there is consistency between the epidemiology of the AIDS epidemic in a particular jurisdiction and the way resources are being allocated to priority activities. There is no set standard for this review. However, if 60% of the reported AIDS cases in a particular jurisdiction were injecting drug users and less than 5% of prevention resources were being targeted to that group, CDC would want to talk to the AIDS Director and the community planning group Co-Chairs to try to understand that discrepancy.

IV. FACTORS INFLUENCING COLLABORATION

A. NASTAD FINDINGS

The NASTAD study's major findings regarding collaboration between prevention and care planning are consistent with the lessons from the case studies.

- **Collaboration of prevention and care planning is in a very preliminary stage.** This is partly a reflection of the compressed time frame available to community planning groups during their first year, when they had to develop a prevention planning structure and membership and complete the steps necessary to develop a prevention plan. Most states and cities found it nearly impossible to consider linking the two processes. Some felt that it was best to devote special attention to HIV prevention programs before linking the planning process with other AIDS services.

- **Certain factors create an environment conducive to collaborative planning.** For example, as demonstrated in the Alabama case study, collaboration seems to be encouraged in areas where:

  - ♦ Relatively few agencies are involved in HIV prevention and care, and many groups "wear both prevention and planning hats." These conditions are especially likely to exist in rural areas.

  - ♦ Health Departments and public health systems are well integrated at both the state and local levels.

- **Collaboration is especially effective when it focuses on certain planning activities which can be done more easily if they are carried out jointly, rather than on tasks which are more easily handled separately.** For example, the following tasks seem to benefit from joint efforts:

  - ♦ Recruiting and nominating planning body members,

  - ♦ Conducting an epidemiological profile,

  - ♦ Developing resource inventories, and

  - ♦ Carrying out certain kinds of needs assessments.

On the other hand, the following tasks may be more effective if handled separately; these might include:

- Priority setting, and

- The allocation of resources.

B. DEVELOPING COLLABORATION

A jurisdiction interested in developing collaboration might consider addressing the four questions listed in the box. Responses to these questions are covered in the sections that follow.

FOUR KEY QUESTIONS IN DEVELOPING COLLABORATION

1. Why collaborate?
2. What is a "collaboration"?
3. What are the barriers to collaboration?
4. What are some preventive strategies to minimize these barriers?

C. BENEFITS OF COLLABORATION

Individuals involved in prevention and care planning have identified many reasons to collaborate, including the following:

- To identify gaps in current services and cooperate to fill those gaps;
- To expand available services through cooperative programming;
- To provide better services through inter-agency communication;
- To develop a greater understanding of community needs by seeing the entire picture, not just a snapshot along the continuum of the response to HIV/AIDS;
- To share similar concerns and be enriched by diverse perspectives;
- To reduce inter-agency conflicts and tensions by squarely addressing the issues of competition and turf, improve communication with organizations in the community and through them reach larger segments of the community;
- To mobilize collective action to effect needed changes;
- To achieve greater visibility in the community;
- To enhance staff skills;
- To conserve resources by avoiding unnecessary duplication;
- To decrease costs through collective buying and other cost containment; and
- To start developing a community-based public health response to AIDS that is not based solely on the funding stream.

D. OBSTACLES TO COLLABORATION

Among the identified barriers to collaboration are the following community-related factors:

- Conflict of interest;
- Perception of bias or perceived attempts to influence a process;
- Difficult past or current relationships among participants;
- Racial or cultural polarization in the community; and
- Differing community norms and values regarding cooperation.
- Loss of focus on the respective missions and goals of prevention and care.

In addition, several potential obstacles relate to differences in program guidelines and requirements, especially differences in structure, timelines, definitions, funding requirements, reporting requirements, and geographic planning areas. These factors are summarized below.

OBSTACLES TO COLLABORATION BETWEEN PREVENTION AND CARE PLANNING BODIES

- Different guidelines, terms, and definitions for CDC and HRSA planning bodies
- Substantive differences in responsibilities and processes
- Short time frame available to CDC prevention planning bodies during their first year

1. SUBSTANTIVE DIFFERENCES IN RESPONSIBILITIES

As noted earlier, HIV Prevention Community Planning Groups and CARE Act consortia and planning councils have comprehensive planning responsibilities, while their roles differ in terms of the allocation process. Fully merging the two planning functions is complicated by these differences, although the differences need not negatively affect joint implementation of certain tasks such as assessing the epidemic, identifying resources and service providers, determining unmet needs, and identifying priority interventions and strategies.

2. DIFFERENCES IN PROCESSES, TERMS, AND DEFINITIONS

CDC and HRSA planning bodies have different procedures and guidelines regarding decision making. These differences can complicate efforts to merge the two planning processes. For example, the Delaware Title II consortium uses a process through which issues are raised and discussed within one of five standing committees, then recommendations are brought to the board and finally to the general membership of the consortium, which has the most diverse representation and takes the final action. However, CDC guidelines indicate that the prevention committee, which must meet certain representation requirements, should have the last word and the last vote on recommendations related to HIV prevention planning. This means that if the two planning groups are merged and HIV prevention planning is made the responsibility of a prevention committee, that committee cannot function like the other standing committees, and must operate without the checks and balances provided by the board and full consortium.

CDC and HRSA also use some different terms and definitions. For example, Delaware calls its HIV Prevention Community Planning Group the Prevention Committee, but CDC continues to use the other name. Use of two different terms for the same entity can be confusing to people within the state.

3. TIME CONSTRAINTS

The short time frame available to CDC prevention planning bodies during their first year presented a major challenge to collaboration efforts. Many states had their hands full establishing planning bodies, completing needs assessments, and preparing their applications to CDC. Limited time was available to determine appropriate collaboration or to make it happen. These time factors are far less demanding now that the first year of HIV Prevention Community Planning is over.

E. STRATEGIES FOR FACILITATING COLLABORATION

SEVEN HINTS FOR MINIMIZING OBSTACLES TO COLLABORATION

1. Keep your commitment and activities clearly defined.
2. Make clear communication your top priority.
3. Encourage all participants to be up-front about their needs.
4. Don't avoid the issues of turf and hidden agendas; encourage negotiation and communication to address them.
5. Make strong commitments to an ongoing, aggressive outreach program to ensure involvement of diverse individuals and groups and inclusion of all perspectives within the community.
6. Develop clear roles for the leaders and participants, and clearly define where they meet.
7. Don't be afraid to celebrate your accomplishments and recognize when you are doing a good job -- and say it to each other.

Regardless of the type of collaboration or cooperation, certain factors are closely related to successful experiences:

- Clearly defined missions or purposes which are mutually agreed upon;
- Active involvement of all participants in the overall planning process;
- Clearly defined operating procedures and definitions of everyone's roles and responsibilities; and
- A communication system which includes information sharing and planned discussion of inter-agency competition, vested interests, and turf issues.

The box provides a list of actions which jurisdictions can take to help minimize barriers to collaboration.

V. CONCLUSIONS AND EVALUATION

A. CONCLUSIONS

Both HRSA and CDC believe that coordination and collaboration between CDC HIV Prevention Community Planning groups and both CARE Act Title I Planning Councils and Title II Care Consortia are vital to creating and maintaining a continuum of care for people at risk for HIV and those living with HIV disease. HRSA believes that to plan effectively for this continuum, HIV care planning bodies, planning councils, states, and consortia need to coordinate with prevention planning groups. CDC has an explicitly stated expectation that there will be both collaboration and information sharing between prevention and care planning activities. Both entities also recognize that such collaboration can take many forms. The Guidances issued by both entities ask for information about collaboration between prevention and care planning bodies, but recognize the need for flexibility in how that collaboration occurs in any specific state or area.

Collaboration between prevention and care planning bodies is in its early stages. During the first year of HIV Prevention Community Planning, less than 10% of grantees chose to merge their prevention and care planning processes. Some additional jurisdictions were involved in more limited collaboration. CDC HIV Prevention Community Planning began in 1994, and the compressed time frame available to community planning groups for developing a prevention planning structure and membership and completing the tasks necessary to develop a comprehensive HIV prevention plan limited the time available for developing collaboration. Both HRSA and CDC expect that cooperation and collaboration will increase in future years.

Case studies from selected Title I and Title II jurisdictions identify a wide range of types of collaboration, from a consolidated planning group to memoranda of agreement which call for some joint activities, some shared membership, and/or information sharing. Certain types of activities, such as the development of an epidemiological profile, other components of needs assessments, and development of resource inventories seem particularly appropriate for joint efforts. Others, such as priority setting, may be more effective if handled separately.

Although HIV Prevention Community Planning is similar to CARE Act planning in terms of certain planning group responsibilities and processes, the two differ in terms of the priority setting and resource allocation processes. Both HIV Prevention Community Planning Groups and CARE Act planning bodies have comprehensive planning responsibilities. In HIV Prevention Community Planning, the Health Department has sole responsibility for resource allocation. Under the CARE Act, however, the Title I Planning Council has the additional responsibility for establishing the allocation of resources across service priorities (usually done as an absolute dollar amount or as a percentage). CARE Act Title I Grantees have the administrative responsibility of soliciting and awarding contracts that result in service provision consistent with established priorities (the procurement process). The relationship between a Title II Consortium and the CARE Act Title II Grantee is somewhat similar to the relationship between

the HIV Prevention Community Planning Group and the Health Department concerning the allocation of funds, although this is not necessarily always the case given the variety of consortia models.

Certain factors create an environment conducive to collaborative planning. Collaboration has been shown to work well in jurisdictions which are relatively rural with a limited number of community agencies conducting HIV/AIDS-related activities, and in jurisdictions which have Health Departments and public health systems that are well integrated at both the state and local levels.

The experience gained to date suggests both the value of collaboration and some strategies which contribute to successful joint efforts. Effective collaboration can make effective use of human and financial resources, improve the extent and quality of planning, and help to create and maintain a continuum of care including both prevention and treatment. Collaboration is mutually beneficial when the two bodies have jointly agreed upon clearly defined missions or purposes, developed well-defined roles and responsibilities, ensured active involvement of all participants in the planning process, and established and maintained ongoing information sharing and open discussion of inter-agency competition, turf, and other potentially divisive issues.

B. EVALUATION

Participants in each conference call are encouraged to complete brief written forms asking for evaluation feedback, suggestions/comments, and recommendations for follow-up to the national CARE Act technical assistance provider for analysis. Thirty-four evaluations were received for this conference call; the full evaluation report is included as Appendix C. Major results are summarized below.

- **Respondents found the content of the call both timely and informative.** This was the first concrete information Ryan White grantees have received about CDC planning groups, and inclusion of both HRSA and CDC representation was very helpful. Most useful was the information provided through local examples and success stories illustrating collaboration between prevention and care planning groups. Respondents felt that time was divided appropriately between presentations and questions, and that question and answer periods were appropriately scheduled.

- **Respondents strongly urged timely written follow-up,** including this written report and other supporting materials. Some respondents would like to receive timelines and written information from states and cities with successful

collaboration activities, names and addresses of presenters, and/or copies of speakers' presentations.

- **Respondents suggested various types of additional follow-up,** including sharing of urban versus rural models, organizing panels on specific collaboration approaches with both CARE Act and CDC planning group representatives, evaluating states' collaborative efforts after six months, producing a paper providing additional information about local experiences and approaches for improving collaboration, and conducting a follow-up conference call on the same topic in a few months.

- **Many respondents requested more written information prior to the conference calls,** from copies of presentation outlines to a presenter list with contact information. Several respondents felt it would be helpful to receive a tentative agenda along with the announcement of the conference call.

- **As with past conference calls, some respondents felt that too much information was presented in a short time period,** causing speakers to be rushed and information to be presented too quickly.

Turnaround time for written reports has now been reduced to about six weeks. Distributing more information before the calls is difficult since the agenda is designed based on questions from the field. However, several changes in the process are being considered in order to make in-depth materials available prior to the call. Complete presenter lists cannot be distributed before the calls, since the complete group may not be confirmed until a few days before the call.

APPENDIX A:
PANELISTS

FACILITATOR

Jon Nelson, Chief, Planning and Technical Assistance Branch, Division of HIV Services

PANELISTS

Anita Eichler, Director, Division of HIV Services

Ronald O. Valdeserri, Acting Deputy Director, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention

Steven Young, Chief, Eastern Services Branch and Acting Chief, Western Services Branch, Division of HIV Services

Jane Cheeks, Director, Division of HIV/AIDS Prevention and Control, Alabama Department of Public Health

Jack Jourden, STD/AIDS Administrator, Seattle-King County Department of Public Health

Joseph Kelly, National Alliance of State and Territorial AIDS Directors (NASTAD)

Randy Pope, Chief, HIV/AIDS Prevention and Intervention, Michigan Department of Public Health

Bill Stackhouse, Director, Prevention Planning and Evaluation Unit, New York City Department of Health

Donna Yutzy, Consultant to the Division of HIV Services, Sacramento, California

COORDINATORS

Miguel Gomez, TAC Project Officer, Division of HIV Services

Kim Simonian, TAC Special Projects Coordinator, John Snow, Inc.

APPENDIX B
AGENDA

Agenda

Collaboration Between Titles I and II Ryan White Planning Bodies and CDC HIV Prevention Community Planning Groups

Technical Assistance Conference Call
Monday, September 18, 1995 2:00 - 3:00 PM Eastern

I. Introductions

II. Federal Level Questions

A. What is the current status of CARE Act reauthorization'? Does the legislation mention collaboration with CDC HIV Prevention Planning Groups'?

B. Does the current application guidance for Titles I and II mention collaboration with CDC Prevention Planning Groups'?

C. What are HRSA's expectations related to collaboration between Titles I and II Grantees and CDC HIV Prevention Community Planning Groups'?

D. Does the current application guidance for CDC Prevention Planning Groups mention collaboration with Ryan White?

E. What are CDC's expectations related to collaboration between Titles I and II Grantees and CDC HIV Prevention Community Planning Groups'?

F. How much collaboration is occurring'?

Questions from Participants

III. General Level Questions

A. How can the Ryan White and CDC planning bodies work together?

B. M'hat technical assistance is available to help Ryan White grantees work on this issue'?

IV. Title I Grantee Level Questions

Describe examples of Planning Councils and CDC Planning Bodies that are working together.

V. Title II Grantee Level Questions

Describe examples of Title II grantees and CDC Planning Bodies that are working together.

Questions from Participants

VI. Closing Comments

APPENDIX C:
EVALUATION REPORT

I .

RYAN WHITE TECHNICAL ASSISTANCE CONFERENCE CALL

"Collaboration Between Title I and II Ryan White Planning Bodies and CDC HIV Prevention Community Planning Groups"

SUMMARY OF PARTICPANT EVALUATIONS

Collaboration between Title I and II Ryan White planning bodies and CDC HIV Prevention Community Planning Groups was the topic of the seventh call in the technical assistance conference call series. on Monday September 18th. 1995.

One hundred seventy-four sites listened to the conference call. including Ryan White Title I and II grantees. Planning Council and Consortia members. Ryan White funded provider agencies. and CDC HIV Prevention Community Planning Groups. Questions on issues related to this topic were submitted by conference call registrants prior to the call. and were included in the conference call agenda.

Speakers from the Division of HIV Services (DHS) were Anita Eichler. Director. DHS. and Steven Young. Chief. Eastern Services Branch. DHS. Representing the Centers for Disease Control (CDC) was Ron Valdeserri. Acting Deputy Director for the Division of HIV/AIDS Prevention CDC.

Contributing speakers consisted of the following:

- Jane Cheeks. Director. Division of HIV?AIDS Prevention & Control. AL DPH
- \+ Jack Jourden. STD?AIDS Administrator. Seattle/King County DPH
- \+ Joseph Kelly. National Alliance of State and Territorial AIDS Directors
- Randy Pope. Chief. HIV/AIDS Prevention & Intervention. MI DPH
- Bill Stackhouse. Director for the Prevention Planning and Evaluation Unit. NYC Dept. of Health
- Donna Yutzy. Consultant to DHS. Sacramento. CA

This report is based on the thirty-four evaluations that were received from conference call participants during the two weeks following the call. Listeners applaud the information shared by using local examples to illustrate collaboration in this area. Examples of success stories continue to be a popular means to exchange information. The request for written follow-up materials is voiced throughout the evaluations. as well as a need for more written information prior to the call.

This report is comprised of four main areas. brought forth by the participants' evaluations. They are: 1) suggestions or comments regarding this conference call: 2) recommendations for follow-up to this conference call: 3) recommendations for future conference calls: and 4) suggested actions for improvement

Suggestions or Comments Regarding this Conference Cdl

Respondents agree that the content of this conference call was timely and informative. Most useful were the local esamples -- models of success stories from across the country. Listeners also believe that the time during the call was divided effectively between presentations and questions from the audience. Presentations were a good length: question and answer periods fell during appropriate breaks in the agenda. Some praise the technical coordination of the conference call. complimenting the speakers for being clear and understandable. while several complain of difficulty connecting to the call and of static on the line.

Random suggestions and comments include the following:

+ It was difficult to hear the questions from listeners: the moderator should paraphrase them.

- Speakers were well selected: there was a good balance between federal and local officials.

- It was useful to have both HRSA and CDC representatives on the call together.

- This u-as the first concrete information that Ryan White grantees have received on CDC Planning Groups.

Recommendations for Follow-Up to this Conference Call

Most respondents request *timely* written follow-up One praises the turnaround time of the Quality Assurance conference call report. Several ask for an actual transcript of the call. while others advise including timelines and written information from states and cities with successful collaboration activities names and addresses of presenters. and copies of speakers' presentations.

Other suggestions include the following:

- Share rural versus urban models of collaboration.

- Organize panels on specific situations of collaboration. with Ryan White ***and*** Planning Group representatives as panelists.

- Evaluate states' efforts in this area after six months.

- Produce a paper on additional ways to improve collaboration. surveying other states' experiences.

+ Conduct a follow-up conference call on this topic in three months.

Recommendations for Future Corrference Calls

Mentioned throughout the evaluations is the need for more written information prior to the conference calls. Several would have liked copies of presentation outlines to follow along w ith during the call. as well as a list of presenters and contact information. Also, receipt of agendas earlier. perhaps a tentative agenda with the announcement of the call. is a suggestion.

Past calls have been criticized for presenting too much information in a short time frame. causing speakers to be rushed. Several feel that this call also should have either been longer. or contained less information.

Actions for Improvement

The evaluations for this conference call continue to mention the desire for written follow-up material. Another common theme running throughout the evaluations is the need for more written information beforehand. in preparation for the call.

In response to previous suggestions from conference call participants. we are working on decreasing the turnaround time for written follow-up reports. The system for conference call report production has been standardized. and the last conference call report was mailed out within six weeks of the conference call.

Distributing more information prior to the conference calls is difficult. given the process of designing the agenda from participants' questions. Based on committee input. we have tried to narrow down the conference call topics in the confirmation mailing so as not to raise unrealistic expectations of the conference calls. However. the entire process can be changed in several ways to.facilitate the availability of more in-depth written materials prior to the calls. Clustering of the questions received from the field can begin on the registration deadline by one or two committee members. in order to produce a tentative agenda for inclusion with the confirmation mailing. Another idea is to hold the planning and rehearsal calls more than a week before the actual 'conference call. so as to produce a complete final agenda that can be faxed to registrants an entire week before the call itself. Lists of presenters and contact information are included in follow.-up reports: it is an unrealistic goal to include this information in its entirety beforehand. as it is often unconfirmed until several days before the call.

APPENDIX D:
NASTAD SURVEY REPORT

NASTAD Issue Brief

a publication of the National Alliance of State and Territorial AIDS Directors
October 1995

Collaborative Planning for HIV Prevention and Care: State and Local Experiences

While most states and localities carry out their HIV/AIDS planning activities for prevention and care under two separate tracks, a small but increasing number of areas are undertaking efforts to more closely link or fully merge their planning activities. This finding comes from a 1995 NASTAD survey of state AIDS coordinators and follow-up interviews with select states. The review also determined the characteristics. motivations. and potential drawbacks to collaborative HIV/AIDS prevention and care planning.

NASTAD, through funding from the George Gund Foundation. conducted the review in order to determine if collaborative planning represents an opportunity for enhancing HIV/AIDS prevention and care planning and programs. NASTAD's survey found that only six out of 65 state and local grantees reported that prevention planning is coordinated with Ryan White CARE Act planning. This represents roughly ten out of about 200 community planning groups in the country reportedly coordinating planning efforts for HIV prevention and HIV care services. The states are Alabama. Delaware, Florida, Michigan, Washington state, and the city/county of Los Angeles. Several other project areas reported to NASTAD that while planning is not jointly configured or directly coordinated, there exist elements of state or local planning which facilitate some more modest level of collaboration of HIV prevention and care. These areas include California, Chicago, Maryland. New Mexico. New York. and Utah.

Why have these areas undertaken collaborative planning'? Discussions with states involved with collaborative planning provided descriptions of more cost-effective and streamlined use of planning resources. such as sharing of epidemiologic profile data. resource inventory data. and needs assessment findings. Also touted was enhanced attention to the continuum of services across the prevention. early intervention, and care spectrum, suggesting that separate prevention and care planning might overlook the gray area of early intervention services. For some states, collaboration occurs in a relatively straightforward manner because the same individuals serve on both prevention and care planning groups, and many HIV/AIDS agencies are both prevention and care providers.

Yet the NASTAD review also established that there is no en masse movement toward collaborative planning across the country. Tempenng factors include concerns that full integration could potentially diminish attention to either prevention or care issues, along with the perspective that care and prevention planning are so substantially different in their approaches as to warrant separate processes. The history behind creation of separate planning for care and prevention -- the presence of distinct constituencies, funding streams, and agencies involved in each field -- have also limited collaboration.

From the federal level. HRSA and CDC guidance documents have urged collaboration But neither agency has determmed that specific types of collaborative planning are effective, perhaps because so little IS known about the benefits and drawbacks. Therefore, states and localities are well-positioned as laboratories for collaborative planning given their role as coordinators for both Ryan White CARE Act services and CDC prevention efforts.

This report presents a review of collaborative planning activities currently underway in select states. Following is an overview of findings about activities underway as determined through NASTAD's in-depth interviews with state and local officials, pros and cons of collaborative planning, and a detailed look at activities in four states. It is hoped that these findings will assist state and local health departments and community planning bodies in their efforts to develop collaborative HIV/AIDS planning approaches.

Summary of Findings

NASTAD conducted more m-depth interviews with four of the project areas conducting collaborative planning -- Alabama. Florida, Michigan and Washington. Among the major findings:

- In all cases, collaborative care and prevention planning is in a preliminary stage. The compressed time frame to do a comprehensive prevention plan and application to CDC in the first year of community planning (1994) made it nearly impossible for most states and cities to consider linking the two processes from the start. In fact, many areas opted not to coordinate the two planning processes -- at least for the time being -- in order to devote special attention to HIV prevention programs separate from other AIDS services.

- Several factors seem to create an environment more conducive to collaborative planning. Among the kinds of places collaborative planning seems to happen more readily: 1) areas with fewer AIDS cases or where fewer agencies are involved in HIV care and prevention work. for instance. rural areas where many of the participants are directly involved in both prevention and care services. and 2) areas where state and local health departments are administratively linked.

- Areas reported to NASTAD that collaborative planning can work by recognrnzing that some planning activities are easier to do jointly. Examples include nominating and recruiting members. producing epidemiological profiles. and resource inventones. Others, such as priority setting and allocation of resources. may be more effective if handled separately.

Practically speaking, many prevention and care planning processes around the country are engaged in overlapping initiatives. For example, programs focusing on secondary prevention interventions. and efforts to reduce perinatal HIV transmission. are being funded through both HIV prevention and Ryan White CARE Act planning processes nationwide; these areas represent natural initiatives for collaborative work. In fact, both CDC and HRSA, through their respective program guidance materials, expect that grantee comprehensive plans are developing programs regarding secondary prevention as well as implementing ACTG 076 clinical guidelines and outreach to pregnant women.

It is important to bear in mind that prevention and care planning efforts have been organized differently across the nation, and the distinctions are clear. The placement of authority for prevention and care resource allocation has been structured differently at the state and local levels. For example, CDC prevention planning groups serve mostly in an advisory capacity to state and local health departments. Their role is to assess unmet needs, identify strategies for meeting those needs, and set priorities for funding in partnership with state and local health departments. Ryan White

Title II planmng bodies also have a largely advisory role, and their plannmg mission has been defined primarily by states given that the federal legislation does not provide specific guidance in this area. Ryan White Title I planning councils -- appointed by mayors and county executives -- have greater statutory autonomy to allocate resources based on planning prionties. In many cases these structural differences limit the ability of the two processes to directly coordinate.

NASTAD's findings Indicate that these differences need not obscure the potential for collaborative planning. The examples provided by states and localities currently attempting care and prevention planning partnerships reveal numerous benefits to collaboration. The efforts, when appropriately linked, can improve the identification of service gaps, expand available services. reduce interagency conflicts, prevent duplication of effort, conserve shrinking resources, and in some examples, improve. relationships among agencies and individuals who have been in competition to work toward common goals. Clearly, in many areas there appears a sense of urgency to collaborate now uncoordinated planning activities being carried out by multiple Title I EMAs, Title II consortia and CDC planning groups. Many project areas are calling out for examples of places that are jointly conducting prevention and care planning.

Collaboration Cons and Pros

The fact that only a small percentage of project areas around the country are engaging in collaborative planning activities suggests that significant hurdles currently exist. The task of coordinating elements of prevention and care planning, from start to finish, is not easy. The four project areas identified difficult aspects of coordinated planning and factors which represent barriers which stand in the way of collaboration. These barriers mclude:

Barriers

- HRSA and CDC require planning documents to be submitted in different formats;
- concurrent care and prevention planning deadlines can place burdens on administering agencies:
- there is a need to account for timing and demands that would be placed on state staff people to support both care and prevention planmng: the two processes can't overlap too much since current timelines established by the federal government fairly well accommodate accomplishment of care and prevention planning for different time periods;
- there is fear that direct care could overshadow prevention because care's focus is more concrete (e.g., easier to document delivery of services to a given number of clients) as compared to prevention (i.e., it is difficult to document the results of prevention encounters on behavior change);
- it is more feasible for care-planrung to see its efforts to an end stage (e.g., care can develop a service plan, implement it. and evaluate if clients receive services);
- prevention planmng is more ambiguous because the planmng group itself may not be involved with the end result/intervention;
- there is difficulty in balancing time spent on care planning v. prevention planning;
- care in many instances receives greater funding and is thus seen as having more impact on clients;
- there is fear that coordinated planning will mean that something has to be given up (e.g., prevention people fear that care services will eat up prevention money: care people feel that prevention is less important than caring for people who are sick);

Barriers (Con t'd)

- balancing the need to get the right people to participate in both care and prevention planning against the desire to limit the number of planning participants to a manageable size (e.g.. around 30 persons maximum) :
- in one state. prevention planners are reticent in dealing with care planmng because care planners are reportedly more technical, better organized, more medical in orientation:
- in pursuit of avoiding conflict of interest situations on decision-making, care voices may be compelled to abstain from discussion (and prevention perspectives to recuse themselves from prevention issues), leaving a void in expertise when each set of issues are debated, particularly on priority setting; and
- each type of planning may require different types of people: care planning requires care agencies (home health, hospice, hospital, volunteer organizations) whereas prevention planning requires such agencies as law enforcement, schools, youth agencies, and people from the community who have a greater interest in prevention.

Facilitators

A number of elements of both prevention and care program planning facilitate better coordination. Here are some of the "facilitators" identified by the four project areas based on NASTAD's review:

- collaboration saves time, money, and effort;
- a single epidemiologic profile is easier to prepare;
- time commitments for planning participants (e.g., time and travel demands to attend meetings) are reduced;
- outreach to potential planning participants. an essential but time-consuming task. is easier to conduct just once.
- in many areas. community agencies conduct both care and prevention work -- joint planning is thus more reflective of their day-to-day work;
- for highly mobilized and coordinated areas. joint planning may be a natural extension of this climate of collaboration.
- in working on both sets of issues. greater sensitivity toward care and prevention concerns is developed (e.g.. in clarifying misperceptions such as the concern that care consumes Rinds);
- prevention and care are less likely to be seen as competing for the same resources;
- better field coordination in HIV work can occur (e.g., enhanced referral mechamsms across the prevention/care continuum. case management staff who work closer with HIV educators. cross-over service delivery in TB control and patient care);
- joint planmng may result in care planning members developing a very strong interest in the prevention agenda and becoming advocates for prevention work. and vice versa;
- collaborative planning can be carried out by recognizing that some planning activities are easier to do jointly (e.g., epi profile) whereas others (e.g., priority setting) may be more effective if handled separately.

The overall message from the four sites: collaboration may not require vast changes to the current system of prevention and care planmng. But it may require states and localities to rethink how they do business, and recognize the potential benefits of identifying elements of each planning process which may integrated.

State/Local Experiences with Collaborative Planning

The following are bnef descriptions of collaborative care and preventron planmng experiences in four states -- Alabama. Flonda. Michigan and Washington -- including the reasons these areas have chosen collaborative planning and specific examples of the kinds of collaboration that are currently happening.

Alabama

In Alabama, planmng is regionalized under the state-coordinated public health area (PI-IA) system. Two of eight PHAs have combined prevention and care planning groups while the other six operate separate care and prevention planning bodies. There is a statewide care committee, but no statewide prevention group. The state health department-provides guidance on collaborative planning.

A collaborative planning climate is suggested given the state's largely rural character (i.e., limited number of commumty agencies conducting HIV activities and fewer funds to disseminate, allowing for more straightforward handling of planning process issues), Limited number of ASOs, all of which provide both HIV care and prevention activities, and a state-led PHA system that supports state health department capacity to coordinate care and prevention activities.

Reasons for Collaborating

- avoid duplication of planning efforts;
- efficiency in using one epidemiologic profile;
- desire to have planning focus on the continuum of care across a prevention, early intervention, and care spectrum;
- for rural areas particularly, fear that two separate processes will result in losing people (e.g., travel time to meetings);
- 11 ASOs in state conduct both prevention and care activites. are members of care and prevention planmng bodies. and thus lend themselves to be informed participants under both planning realms: and
- relatively small number of agencies/individuals in Alabama who work in HIV/AIDS. making collaborative planning more workable

Types of Collaboration

- two regional PHAs with combined prevention/care planning bodies;
- state has developed a suggested integrated care/prevention needs assessment format:
- some regional needs assessments cover both prevention and care and are carried out through one survey;
- many of the same individuals/agencies are on both care and prevention planmng groups, which happens not as an intentionally designed process but rather because few agencies are involved in HIV work;
- state prepares an epidemiologic profile and shares it with prevention and care groups, who tailor it as needed;
- prevention and care groups share their plans with each other;
- state coordinates sharing of information among CBOs;
- separate state staff who coordinate prevention and care activities are in close contact and commwcation;
- resource inventones, although prepared separately, involve sharing of information among care and prevention processes; and

- lessons learned from prevention priority setting have been shared with care groups.

Outlook

Alabama: A state representative obsenes that the joint plannmg process is working fairly well at this early stage. although this observation probably would not have been made a year ago.

Florida

The statewide HIV group is focused on both prevention and care while all 12 regions have separate care and prevention groups, structured generally along lines of the integrated state/local health department infrastructure. State guidance on collaborative planning includes a state planning needs assessment tool; a state epidemiologic profile (developed as a national model); a state-prepared resource inventory (prepared from the state HIV hotline); and state health department suggestions on how to conduct coordinated needs assessment activities.

Reasons for Collaborating

- the statewide Title II care group evolved into the state care/prevention group given: the need to develop a comprehensive plan in response to the new CDC prevention initiative; planning members whose agencies had involvement in both prevention and care and were in favor of combining plannmg (including desire to cut down on meetings); and a need to inject new energy mto the statewide group;
- desire to link the state's multiple but uncoordinated planning activities, as conducted by over 1,000 individuals through the state's six EMA planning councils, 12 Title II consortia, 12 CPGs, and five special initiative networks around state funds, Title IIIB, and Title IV;
- state staff time limitations in prepanng epidemiologic profile and resource inventory data separately for care and prevention; and
- level AIDS funding in the face of a growing epidemic is an impetus to increase efficiencies in spending on planning

Types of Collaboration

- statewide prevention/care planning group. where each of state's 12 regions picks three members: patient care. preventlon. and a third member (such as a representative who can speak to both care and prevention);
- state needs assessment tool, part of which is designed to guide development of coordinated care/prevention planning activities (i.e., resource inventory);
- state-developed epidemiologic profile;
- state-developed resource inventory, prepared from the state HIV hotline listing;
- many individuals participate in both prevention and care plannmg bodies.
- recognition that differences exist in planmng for care v. prevention where they should be handled separately (e.g., care-focused entity like a subcommittee to look at quality assurance, standards of care);
- comprehensive care/prevention state plan currently under development.

Outlook

Florida: The state stresses that collaborative planning is in early stages, with some struggles and some successes. The state will continue to pursue collaborative plannmg, given the fear that planning will fall through the cracks under an environment of level funding in the face of an ever-growing epidemic

Michigan

Only one of the state's eight regions has a joint care/prevention planning body (i.e., Grand Rapids area). There are currently separate state care and prevention planmng groups. State policy is leading a major shift toward collaborative planmng, as determined by the governor-appomted Risk Reduction and AIDS Policy Commission. That advisory body's directive is for regional groups to consolidate care/prevention planning over the next two years. The commission has not defined consolidation to be single groups but rather has outlined areas where mutual and parallel efforts could be conducted concurrently.

Reasons for Collaborating

- mandate by Governor's advisory body to collaborate on planmng but ensure that neither agenda of prevention or care is jeopardized or diminished;
- limited state resources to support capacity building and planning require consolidation of planmng activities;
- efficiencies can be realized: and
- community resources can be looked at in a holistic context.

Types of Collaboration

- state staff coordinate activities, dates of meetings, share information, use some of the same data;
- single state epidemiologic profile is used for care and prevention;
- many individuals/agencies serve on both care and prevention groups, with the degree of crossover variable from region to region;
- collaborative activities of the Grand Rapids care/prevention group:
  - joint care/prevention group was formed based upon techmcal advice provided by a research team, which modeled the combined body after the area's substance abuse planning group:
  - regional epidemiologic profile. focus groups of affected populations. and an inventory of available services are reviewed and a "crosswalk" of these data sources is used in determining needs across prevention and care areas;
  - services are looked at regardless of whether they are prevention or care (e.g., types of services that one might need like buddy care, HIV testing and counseling, hospice). and
  - CDC commumty planning process information was used in making the care/prevention planning process work.

Outlook

Michigan: The state urges consolidation of techmcal assistance for areas such as conflict resolution, leadership, needs assessment, and capacity building, where the same type of guidance is applicable for both care and prevention planning contexts. The sole region currently using a care/prevention planning process intends to continue joint planning.

Washington State

A strong focus on regionalized planning exists, in line with 1988 state law establishing six AIDSNets (Networks) to serve as planning/coordination bodies for prevention and care activities. While the regions have separate care and prevention groups, transitions appear underway as some have combined care and prevention planning activities while others appear to be moving in that direction. An area with two years experience with coordinated planning is Seattle-Ring County, a Title I EMA which has a joint care/prevention planning body and also pools

Washington State (Cont'd)

its Title I and II funds under a parity model. A statewide prevention planning group is in place. no statewide care group exists.

Reasons for Collaborating

- regional AIDSNets have asked for leadership from the state. which is currently looking at how to foster increased care/prevention collaborative planning in areas such as timelines. guidance, and use of similar data elements;
- in rural communities. there is sense of burnout with duplicative and time consuming planning processes and an Increased call to do something about planning processes to get more people to participate: and
- there are limits to resources at the regional level to support independent planning processes.

Types of Collaboration

- state health department collaboration achieved by care and prevention office staff through regular meetings, use of a common electronic calendar, and ongoing work to develop a single planning timeline (e.g., consumer surveys to include care and prevention questions; consultants hired to do both processes; scheduling of focus groups);
- state-developed epidemiologic profile;
- variable levels of overlap in membership among regional planning and care groups, which is near 100% in some regions but completely separate elsewhere (i.e., the larger the AIDS caseload, the less overlap);
- **Seattle-King** County collaboration
- single planning body handles prevention and care;
- separate care and prevention subcommittees:
- single epidemiologic profile;
- priority setting separate for preventron and care;
- ongoing re-examination is underway of joint care/prevention planning to address issues around roles and responsibilities. conflict of interest:
- planning body struggling with two issues: to increase number of members above current 30 in order to secure broader care and prevention perspectives v. fear that a larger body would become'unwieldy.

Outlook

Washington State: Given the call from the regional AIDS Nets for state guidance on how to do collaborative planning, the state needs ideas and insights on how to do collaborative planning.

This is the first in a periodic series of special NASTAD reports on current HIV/AIDS public policy issues facing states and localities, produced with the support of the George Gund Foundation.

Environments That Are Conducive to Collaboration

Based on NASTAD's interviews with planning participants in the four states, a number of common factors emerged which appear to create an environment more conducive to coordinated planning. These factors include:

- lower HIV/AIDS caseloads,
- fewer prevention and care resources to disseminate;
- less complexity in HIV epidemic characteristics in terms of different population categories and regions disproportionately affected;
- fewer agencies which are involved in HIV care and prevention work; many of the same individuals currently serve on both prevention and care planning bodies, thus creating a comfortable context for transitioning to collaborative planning;
- rural areas with any or all of the above characteristics; and
- health department systems that are integrated at the state-local level, allowing for closer coordination in planning for submission of federal funding requests.

The National Alliance of State and Territorial AIDS Directors (NASTAD) represents the HIV AIDS program managers **of every** *U.S. state and territory who administer AIDS health care prevention education and supporn ve service programs. including funding provrded through HRSA under Title II of the Ryan White CARE Act and through CDC HIV prevennon cooperative agreements. NASTAD is grateful for the assistance provided by state AIDS directors in preparing this report with particular apprecianon to the following people who provtded special assistance through interviews:*

Alabama. Jane Cheeks *(334) 613-5362.* deNay Porter, Sharon Jordan-Shaver. and Angie Rollin-Taylor

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The National Alliance of State and Territorial AIDS Directors
444 North Capitol Street, NW, Suite 706
Washington, D.C. 20001
(202) 434-8090 Phone
(202) 434-8092 Fax
Wayne E. Sauseda, Chair
Julie M. Scofield, Executive Director